Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MAINLAND SURGERY CENTER 3750 MEDICAL PARK DRIVE, STE. 300 DICKINSON, TX 77539	MFDR Tracking #: M4-09-A761-01
Respondent Name and Box #: HARRIS COUNTY Rep Box # 21	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "…Argus has denied payment for the second implanted stimulator electrode array billed as 63650-59 stating it is included in the payment for another procedure.

An appeal was issued to Argus with supporting documentation showing that it is correct to bill two 63650 as the electrode arrays were implanted at two separate sites according to the AMA and the description of CPT 63650…"

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $2,503.80
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "…In this matter, there was not separate request for reimbursement of an implantable. The proper reimbursement for this non-device intensive procedure is the Medicare ASC facility reimbursement amount multiplied by 153 percent. The Respondent's position is that all payments in this matter were made in accordance with the Medical Fee Guidelines."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
1/21/09	63650-59	97, 193	1-5	$2,428.54
Total /Due:				$2,428.54

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated; and
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Duplicate Appeal. An appeal of the original audit was previously performed for these services."
2. The 1/21/09 operative report indicates the claimant underwent the following:
   - "Fluoroscopic imaging of the lumbosacral spine;
   - Fluoroscopically guided percutaneous insertion of lumbar epidural stimulating electrode array lead 1 and lead 2 for trial of spinal cord stimulation;
   - Intra-operative analysis and programming of spinal cord stimulator; and
   - Post-operative analysis and reprogramming of spinal cord stimulator."
3. On the disputed date, the Requestor billed CPT code 63650 and 63650-59. CPT code 63650 is defined as "Percutaneous implantation of neurostimulator electrode array, epidural." The operative report indicates that two injection sites were performed at the right and left T12-L1.
4. The Requestor submitted a AMA Coding Consultation report that asked the question of how to code for the use of two neurostimulator electrode catheters through two separate sites. The AMA comment was to code the initial as 63650 and the second as 63650-51. The Requestor billed CPT code 63650 and 63650-59. Modifier "-59" was used to identify second lead as "Distinct Procedural Service."
5. Per Rule 134.402(f) reimbursement for device intensive procedure for CPT code 63650-59 is:

   This is a device intensive service and to calculate reimbursement two step process:

   Step 1 calculating the device portion of the procedure:

   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) HCPCs code 63650-59 for CY 2009 = $4,206.45.

   This number multiplied by the device dependent APC offset percentage found on Table 47 for 63650 is 57% = $4,206.45 X 57% = $ 2,397.68.

   Step 2 calculating the service portion of the procedure:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2009 for 63650-= 83.8876.

   This number multiplied by Medicare ASC Conversion Factor $41.393 X 83.8876 = $3,472.36.

   The national reimbursement is divided by 2 = $1,736.18 ($3,472.36/2).

   This number X City Conversion Factor/CMS Wage Index for Dickinson $1,736.18 X 0.9838 = $1,708.05.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $1,736.18 + $1,708.05 = $3,444.23.

   Now, the geographical adjusted ASC rate of $3,444.23 minus device portion $2,397.68 = $1,046.55 the service portion.

   Multiply the service portion by the DWC payment adjustment $1,046.55 X 235% = $2,459.39.

   Now add the device portion and the service portion together to get the MAR. $2,397.68 + $2,459.39 = $4,857.07.

   This number X multiple procedure $4,857.07 X 50% = $2,428.54.

   The MAR for CPT code 63650-59 is $2,428.54. The insurance carrier paid $0.00. The difference between amount due and paid equals $2,428.54.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$2,428.54** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	9/24/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.